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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 7 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 17494

Registrar's No. 4889

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer G Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")

(d) Street No. 1714 Glasgow 9
(If rural, give location)

20

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Callep Crawford

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 2

5. Color or race Col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Betty Crawford

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Dec. (Month) 25 (Day) 1855 (Year)

8. AGE: Years 92 Months 5 Days 0 If less than one day hr. min.

9. Birthplace Tenn. (City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace " (City, town, or county) 9 (State or foreign country)

16. (a) Informant BETTY CRAWFORD
(b) Address 1714 GLASGOW

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof May 29/48 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem

18. (a) Signature of funeral director F. A. GREEN
(b) Address 4214 Delmar Blvd

19. (a) MAY 28 1948 (Date received local registrar) (b) J. T. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1948 hour 10 minute 05 PM.

21. I hereby certify that I attended the deceased from May 17, 1948 to May 25, 1948 that I last saw him alive on May 25, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Degenerative Heart Disease — Undet.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) None

Major findings:
Of operations

Of autopsy No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Oscar L Daniels (M. D. or other)

Address 2601 N Whittier Date signed 5/26/48

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Gaylon H. Swan, Registered Apprentice No. 101, working under my personal supervision.

Signed Fred A. Olson

Licensed Embalmer No. 0963

P. O. Address 4214 DELMAR BLVD

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.